TB Nurse Network Meeting Minutes

April 26, 2012

Present: Patty Raines (MDCH), Katie Dotson (MDCH), Peter Davidson (MDCH), Janet Graham (Barry-Eaton), Margie Surface (Dickinson-Iron), Lisa Hansley (Dickinson-Iron), Renee Crays (Chippewa), Michelle Hammond (Huron Medical Center), Tamara Holsinger-Robinson (Ottawa), Pat Brines (Oakland), Jan Potvin (DHD #10), Denise Bryan (Kent), Bonnie Mellema (DHD #10), Lori Day (Wayne), Becky Stoddard (Mid-Michigan District), Mary Ann Zahn (Dickinson County Healthcare System), Linda Scott (Muskegon), Andrea Reichel (Lenawee), Sue Keen (Ottawa), Patty Feenstra (Ottawa), Kathy Mell (Western UP), Cindy Ockenfels (Chippewa), Pam Quinn (Berrien), Tracy Payne (Jackson)

The meeting was facilitated by Patty Raines.

Upcoming Course Announcements

Patty began the meeting by sharing upcoming course announcements:

- The Spring 2012 issue of "TB TidBits" will be distributed early next week.
- There is a one-day **TB Nurse Case Management** training at Ingham County Health Department scheduled for **June 21, 2012**. The TB Nurse Network decided that it would be best to offer a one-day training during the even years, and the full two-day TB Nursing Certification Course during the odd years. A question was asked regarding the recertification process for the TB Nursing Certification Course. Recertification for people that attended the 2009 and 2011 TB Nursing Certification Course will be done via a competency test. It is not required to attend the training in person.
- A **Tri-State TB Intensive** is scheduled for **October 4th and October 5th** in Lansing. The target audience will be physicians, nurses, and other healthcare personnel from both private and public sectors.
- A two-day skills based **Contact Investigation Interviewing** training will be held in Lansing on **July 25th and July 26th**. This training will have limited capacity. Please contact the MDCH TB Control Program (Katie Dotson or Patty Raines) ASAP if you are interested in attending this training.

Management of LTBI Treatment

Next, the TB Nurse Network discussed Management of LTBI Treatment. Earlier this year, Patty sent out a survey asking people whether LTBI treatment is being managed by the Local Health Department or by private providers. Patty shared some of the survey results:

- One HD stated that they send patients to a private provider if they are insured.
- One HD stated that patients are referred from private providers to the LHD for management of LTBI.
- Some HDs co-provide/co-manage LTBI patients with private providers.
- Some HDs indicated that if the patient is insured, the patient will stay with their private provider for management of LTBI treatment.
- One HD stated that they are responsible for management of LTBI treatment if the individual is a contact to an active TB case.

Janet (Barry-Eaton County) shared that they refer to a private provider only if the client has a PCP. If no PCP, they refer to Ingham County HD LTBI clinic. Barry-Eaton usually refers children to a pediatric ID specialist.

Pat (Oakland County) shared that they generally manage LTBI treatment for individuals that are contacts to active cases and kids under the age of five. Often times, it is still the client's choice. If a private provider is managing a contact to an active case, Oakland County does follow up periodically. Education is also provided to private providers that are managing LTBI clients. Oakland County has a general clinic that handles other LTBI clients.

Tamara (Ottawa County) shared that they manage all LTBI clients in-house.

Cindy (Chippewa County) shared that they usually refer clients to a private provider if they have one.

The group all agreed that there are many people that are being treated for LTBI that the Local Health Department does not know about.

12-WEEK INH-RIFAPENTINE DOT TREATMENT

Patty explained that a new treatment regimen for LTBI is once weekly DOT treatment with INH-Rifapentine x12 weeks. There are still studies being done as well as data being collected regarding the use of this treatment regimen. Patty asked if anyone is using or has used the 12-week therapy?

Cindy (Chippewa County) states that they have used the 12-week therapy (using medication self-administration with a reliable patient) and thinks that it is wonderful.

Pat (Oakland County) shared that a quote for Rifapentine from a supplier was $270.00 for 12 doses.

Patty said that prisoners, contacts to active cases, and students may be good candidates for the 12-week therapy.

Next, the group discussed using Skype for DOT. Janet (Barry-Eaton County) said that they are currently looking into this option for a client, but want to ensure that using Skype does not violate HIPPA. Janet asked if there is a policy in Michigan for video DOT? Janet shared that she has found a couple documents related to video DOT (see links below).

http://www.doh.wa.gov/cfh/TB/Manual/Forms/VDOTTacoma.pdf (Pierce County, WA)

http://ctca.org/fileLibrary/file_242.pdf (California Department of Public Health)

Pat (Oakland County) shared that they do DOT using Skype on and off for one client. Their county computer does not have a camera, so the DOT nurse uses her own personal laptop.

It was suggested that perhaps clients should sign a release of information agreeing to the use of Skype for DOT.

Other HDs said that they would consider using Skype for DOT; however two major obstacles were identified:

- Client does not have a computer
- IT capacity at HD

+QFTs in MDSS

Patty explained that positive QFTs are being dumped into MDSS by reference labs. This was not a decision made by the TB Control Program. What should be done with these labs? How are they being handled by LHDs?

Pat (Oakland County) shared that the follow up for +QFTs coming into MDSS is time consuming. She said that it is sometimes difficult to find the provider that ordered the lab. Why did the provider order the test in the first place? She said that it usually involves making many phone calls and follow-up phone calls.

Another HD indicated that the Infection Control Practitioner at a hospital that orders many QFTs follows up on those.

Some HDs are more burdened by the +QFTs in MDSS than others.

TST/TTT

Patty shared an e-mail that the TB Control Program received from a Master Regional Trainer. The Master Regional Trainer expressed a concern that a medical center within her region said that it is too expensive to send staff to TST recertification classes. Because of this, the medical center talked about developing its own TST training. The Master Regional Trainer believes that MDCH should be the one entity within Michigan to establish standards of practice for TST and TB Control. Is there an alternative to physically attending recertification training? On-line recertification option?

Pam (Berrien County) said that recertification for American Heart involves an on-line test along with coming in to show the skill. Is this a model that we can use for TST recertification?

Denise (Kent County) agreed that time is valuable. She suggested that perhaps recertification could be required every 4 years instead of every 2 years.

Kathy (Western UP) shared that once CEUs were no longer offered, there is no motivation for people to take the training and become competent. She states that people placing the test don't understand what they are doing.

The group shared a common concern that anyone can give and read a TB skin test. Tests are being read and administered wrong.

Patty referenced the MIOSHA document which states, "trained personnel." Patty also shared that just recently, she has received calls that hospitals are requiring that staff involved in giving and/or reading a TB Skin Test must be trained. Michelle (Huron Medical Center) shared that it is their hospital policy that anyone giving and/or reading a TB Skin Test must be certified/trained.

Peter explained that the TB Control Program does not have any regulatory power. It is not within the scope of practice. If The TB Nurse Network wants to push the idea of mandatory training, it will have to be elevated to another part of the State (i.e. LARA, Medical Professionals). It will be a long process.

Pam (Berrien County) shared a tip for getting people to attend her TST Workshops. She sends a flyer to hospitals and includes questions that people will likely be unable to answer (i.e. What is window prophylaxis?).

The group continued to discuss the idea of other options for recertification. Several ideas were offered:

- Taking an on-line test, but being checked off in person on the practicum
    - What about people that live far away from check-off site?
    - Who would check staff off?
    - How would they obtain the practicum arms?
- Hospital Skills Fairs
- On-line test, Check off using Skype
- Patty referenced Appendix F in the 2005 MMWR, "Guidelines for Preventing the Transmission of M. tb in Health-Care Settings." – Quality Control Checklist

Patty and Katie will continue to look at options for on-line recertification.

The group discussed the process of Fast Track Recertification for TST Instructors. Currently, a TST instructor can renew using Fast Track Recertification, in lieu of attending a recertification class in person, if they have taught a minimum of five classes in the previous two years. The group concurred that the criteria for a TST Instructor to renew via Fast Track Recertification would be changed. **The minimum number of classes taught for Fast Track Recertification for instructors will be decreased to <u>four</u> classes in the previous two years.**

<u>Cohort Review</u>

Patty explained that a Cohort Review is different from a case review. She said that typically case reviews are done periodically (i.e. weekly, monthly) while a patient is *currently* receiving treatment. A Cohort Review typically involves reviewing multiple cases, after or close to treatment completion. The purpose of a Cohort Review is to look for markers on how care was done, and to identify problems that may be missed during real-time reviews of individual cases. Patty shared that seven counties in Michigan have done Cohort Review. Cohort Reviews are done in person or over the telephone. So far, comments have been positive. At the conclusion of Cohort Review, counties have identified strengths, barriers and ideas for improvement.

Please contact Patty if you have had a case in the last year and are interested in setting up a Cohort Review or "mock" Cohort Review. The idea of Cohort Review is not to put people on the hot seat.

<u>Sharing</u>

There was a small roundtable discussion regarding a couple of interesting issues:

- Multiple suspect cases – TB of the eye (presented with Uveitis)
- TB of the thumb
- AFB+ client released to a home with 2 children

The meeting was adjourned.

Respectfully Submitted,
Katie Dotson, RN

Next Meeting (Please Note Date Change): Thursday, August 2, 2012 ~ 10:00AM-12:00PM